PRINTED: 05/20/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS2134AGZ 05/13/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8720 W. FLAMINGO ROAD **HERITAGE SPRINGS** LAS VEGAS, NV 89147 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 Y 000 **Initial Comments** The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 5/13/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 100 Residential Facility for Group beds for elderly and disabled persons, Category II residents and 27 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 83. Twenty resident files were reviewed and ten employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of B. The following deficiencies were identified: Y 020 Y 020 449.190(1)(a)-(e) Contents of SS=C License-Administrator's Name NAC 449.190 1. A license to operate a residential facility must (a) The name of the administrator of the facility.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(b) The name and address of the facility;

(d) The maximum number of residents authorized

(e) The category of residents who may reside at

(c) The type of facility;

to reside at the facility; and

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This Regulation is not met as evidenced by: Based on observation on 5/13/09, the facility failed to ensure the vent hose was connected to one dryer located in the personal laundry room #247 allowing lint to build up behind the dryer.

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and rice were uncovered in the dry storage room, which may result in contamination of these food products. Some of the containers of dry food were not properly labeled in the dry storage room.

A styrofoam cup was being used as a scoop for the dry cake mix, and the cup was left in the cake mix, instead of using a proper scoop with a handle that would limit possible contamination of

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NVS2134AGZ

NAME OF PROVIDER OR SUPPLIER

HERITAGE SPRINGS

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

NVS2134AGZ

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING
B. WING
B. WING
B. WING
B. WING
COMPLETED

O5/13/2009

STREET ADDRESS, CITY, STATE, ZIP CODE
8720 W. FLAMINGO ROAD
LAS VEGAS, NV 89147

(X4) ID
PROVIDER'S PLAN OF CORRECTION
(X5)

HERITAGE SPRINGS		8720 W. FLAMINGO ROAD LAS VEGAS, NV 89147					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIC		Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
Y 255	Continued From page 3	Y 255					
	the food product.						
	The cutting board on the cook's line was no longer smooth and easily cleanable.						
	One light bulb in the exhaust hood was burne out and another light was missing its light ship						
	The mop used to mop the kitchen floors was stored in the kitchen instead of being rinsed a properly stored in the janitor's room to dry.	and					
	The mixer, shelves over the food prep table, a the vents at the bottom of the microwave were soiled with food particles.						
	Severity: 1 Scope: 3						
Y 434 SS=F	449.229(3) Emergency Drills	Y 434					
	NAC 449.229 3. A drill for evacuation must be performed monthly on an irregular schedule, and a writter record of each drill must be kept on file at the facility for not less than 12 months after the driven and the schedule.						
	This Regulation is not met as evidenced by: Based on record review on 5/13/09, the facilit did not ensure that monthly evacuation drills conducted on an irregular schedule for 6 of 12 months (May, June, July, August, October, 20 and January 2009); the facility's emergency p did not include direction to staff to remove do stops from doors with automatic closing device and the exit signs located by room #257 and soiled linen room did not work.	were 2 08 olan or ces;					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NUM				(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
				A. BUILDING B. WING	<u> </u>				
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HEDITAGE SPRINGS			8720 W. FL	ET ADDRESS, CITY, STATE, ZIP CODE W. FLAMINGO ROAD VEGAS, NV 89147					
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Y 434	4 Continued From page 4			Y 434					
	Severity: 2 Scope:	3							
Y 444 SS=C	NAC 449.229 9. Smoke detectors roperating conditions tested monthly. The to this subsection mumaintained at the factory. This Regulation is not based on record revi	must be maintained in p at all times and must be results of the tests purs ust be recorded and	e suant	Y 444					
	was available for review at the facility for 12 out of the past 12 months (May 2008 to April 2009). Severity: 1 Scope: 3		out of						
Y 876 SS=D	resident needs the ca caregiver may assist controlled substance	se provided in this ver shall assist in the dication to a resident if the aregiver's assistance.	nly if	Y 876					
	Based on interview a		3/09,						

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